2160 S. First Avenue, Maywood, IL 60153

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name (Print): ________________________________ Date of Birth: ____________________
Telephone Number: ________________________________ Social Security Number (Last 4 digits) XXX-XX-__ ___
Address: ____ City, State, Zip Code: ________________________________

The undersigned hereby authorizes and requests:

- ☐ Loyola University Medical Center, Director of Medical Records and/or her designee
- ☐ Gottlieb Memorial Hospital, Director of Medical Records and/or her designee
- ☐ Other: ____ (Hospital/Physician/Nursing Home/ Clinic)

to disclose and furnish this requested information to the person/facility below. The potential for this information to be redisclosed by this person/facility exists and the information disclosed will not be protected by applicable federal/state laws governing the use and release of your health information:

Name of person/facility to be released to ____
Address (City/State/Zip Code) ____
Telephone Number (____)____

Dates of treatment/service to be released: ____
Purpose for which this information is to be released: ____

INFORMATION TO BE RELEASED (Check all that apply)

- ☐ Lab results ☐ Outpatient records ☐ Emergency Room Record
- ☐ Cardiac Cath report ☐ Immunization Record ☐ Pathology written report
- ☐ Radiology written report ☐ Operative Report ☐ Pathology slides/blocks (pick up in Pathology Dept)
- ☐ Radiology films/digital images and written report (pick up in Radiology Dept)
- ☐ Abstract (Discharge Summary, Operative Reports, History & Physieal, Xray/Radiology written report, Lab results, Consultations if applicable)
- ☐ General Medical Record (Abstract information above and i.e.: orders, notes and interdisciplinary care records filed to date)
- ☐ Other (Specify): ____

SECTION A: If your health information contains *any of the following*, please check all categories that apply in order to avoid delay. By checking any of these categories, you are authorizing the release of the following information:

- ☐ Psychiatric/mental health or developmental disabilities information (Parent/guardian co-signature is required for the release of psychiatric information of patients 12-17 years old)
- ☐ AIDS/related illness, diagnosis/treatment ☐ HIV test results ☐ Genetic testing ☐ Alcohol/drug abuse diagnosis/treatment

You must acknowledge that you are checking these categories by furnishing your written signature here: ____________

SECTION B: This authorization is valid until ___/___/___ (You must specify the month, date and year or we cannot process this rec However, any consent given with respect to substance abuse records shall have a duration no longer than is reasonably necessary to effectuate the purpose for which it is given. You have the right to revoke this authorization except that such revocation will not apply to any uses and disclosures of your information that are described in the LUHS or GMH Notice of Privacy Practices or otherwise allowable under any Federal or State laws. In the event of revocation, any prior use of any information up to that date of revocation may not be retracted.

I know that Imay inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by federal privacy regulations. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose my medical records described in this form to the person(s) and/or organization(s) named in this form.

To revoke this information, write to the Director of Medical Records, Loyola University Health System, 2160 S. First Avenue,Maywood, Illinois, 60153. Include a copy of this authorization with your correspondence.

Patient/Representative Signature: ____ **Date:** ____________________
State your relationship to the patient if the patient is unable to sign or the authority you have to act on behalf of the patient. You must be able to furnish proof of relationship or authority to act for the patient: ____